Bureau of Health Care Quality and Compliance ABGC 4/8/11 c. J

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2489AGC	A. BUILDING _____ B. WING _____	C 03/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANCELLOR GARDENS OF THE LAKE	2620 LAKE SAHARA DRIVE LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of a complaint investigation conducted in your facility from 1/4/11 through 3/15/11. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility was licensed for 150 total beds, 120 elderly or disabled persons, and/or persons with mental illnesses, and/or persons with chronic illnesses and/or provides assisted living services and 30 persons with Alzheimer's disease, Category II residents. The census at the time of the survey was 97. Complaint #NV00027292 was substantiated. See TAGs Y0050, Y0053, and Y0515.	Y 000		
Y 050 SS=G	449.194(1) Administrator's Responsibilities-Oversight NAC 449.194 The administrator of a residential facility shall: 1. Provide oversight and direction for the members of the staff of the facility as necessary to ensure that residents receive needed services and protective supervision and that the facility is in compliance with the requirements of NAC 449.156 to 449.2766, inclusive, and chapter 449 of NRS.	Y 050 OK c. J 4/8/11	**TAG 050** The Security doors to Saras's have been Adjusted and the Patio door alarm has Been replaced with a longer tone alarm And a much louder alarm. (work orders attached) We have a quote for raising the height of the Fence and should have that done by April 30th, 2011. (quote attached)	

f deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: ADMINISTRATOR — (X6) DATE: 4-7-11

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Y 050	Continued From page 1	Y 050		

This Regulation is not met as evidenced by:
Based on interview, record review and observation from 1/4/11 through 3/15/11, the administrator failed to provide oversight and direction to the staff to ensure 1 of 30 residents in the memory care unit received the needed services and protective supervision they required.

Findings include:

On the morning of 1/4/11, Resident #1 was able to exit the facility's memory care unit through an alarmed door located in the dining area. The resident is then alleged to have utilized a dining chair to climb that was left out on the patio to get over the fence that enclosed the memory care unit courtyard. Facility staff reported that the resident was last seen at 2:45 AM on 1/4/11.

Interviewee #1 reported facility and area searches were conducted but the resident was missing from 1/4/11 to 1/10/11. On 1/10/11 at approximately 1:30 PM, Resident #1 was observed riding a city bus by a facility employee. The police, ambulances, facility personnel and family responded to the call. The resident was transported to a local hospital where he was admitted on a Legal 2000 - psychiatric hold.

See Tag: Y0515

This was a repeat deficiency from the 11/2/09 State Licensure survey.

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Y 050	Continued From page 2 Severity: 3 Scope: 1	Y 050		
Y 053 SS=D	449.194(4) Administrator's Responsibilities-Complete Rec NAC 449.194 The administrator of a residential facility shall: 4. Ensure that the records of the facility are complete and accurate. This Regulation is not met as evidenced by: Based on interview, record review, and observation from 1/4/11 through 3/15/11, the administrator failed to keep the records of the facility complete and accurate for 1 of 30 residents (Resident #1). Findings include: On 2/15/11, a review of Chancellor Gardens of the Lakes Two Hour Checks conducted for Resident #1 on 12/16/10 documented that Resident #1 was located in his bedroom at 4:00 AM, 6:00 AM, 8:00 AM, and 10:00 AM. A review of two incident reports completed by the facility for Resident #1 on 12/16/10 indicated that Resident #1 was taken to the hospital at 4:00 AM and returned to the facility by Las Vegas Metropolitan Police Department at 11:00 AM after leaving the hospital against medical advice. Therefore, the two hour checks documenting that Resident #1 was in his room from 4:00 AM to 10:00 AM were not accurate.	Y 053 OK c.7 4/8/11	**TAG 053** Two employees were disciplined (2 days off each) For failing to carry out their 2 hour checks On Mr. Avillar. All Sara's staff was counseled On the importance of 2 hour checks and The risks involved with wandering Residents. (Documentation attached) (Copy of elopement counseling sheet and Information attached)	

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Y 053	Continued From page 3 Severity: 2 Scope: 1	Y 053		
Y 515 SS=G	449.259(1)(a) Supervision of Residents NAC 449.259 1. A residential facility shall: (a) Provide each resident with protective supervision as necessary. This Regulation is not met as evidenced by: Based on interviews and record review from 1/4/11 through 3/15/11, the facility failed to provide protective supervision for 1 of 30 memory care residents to prevent residents from leaving the facility unattended. Findings include: On the morning of 1/4/11, Resident #1 was able to exit the facility's memory care unit through an alarmed door located in the dining area. The resident is then alleged to have utilized a dining chair that was left out on the patio to get over the fence that enclosed the memory care unit courtyard. Facility staff reported that the resident was last seen at 2:45 AM on 1/4/11. Interviewee #1 stated they determined that prior to leaving the facility, Resident #1 was able to take fingernail files and money from caregiver's hand bags. Interviewee #1 reported facility and area searches were conducted but the resident was missing from 1/4/11 to 1/10/11. On 1/10/11 at approximately 1:30 PM, Resident #1 was observed riding a city bus by a facility employee.	Y 515 OK 4/8/11 L.J.	**TAG 515** Med Techs / Care Givers have been counseled to Lock up their personal items (Purses / ETC) so that no personal items are accessible to Residents. Staff Members have been and are continually Being reminded that 2 hour checks need to be done. We have added a third staff member on nights to facilitate Resident safety checks. (Schedule Attached) The Logs are being checked by the Unit Manager. Metro missing person's bureau was notified immediately and calls were made to Hospital emergency rooms to look for Mr. Avillar after he disappeared. These calls were repeated numerous times. Since this incident occurred we have replaced The Unit Manager in Sara's Garden.	

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Y 515	Continued From page 4 The police, ambulances, facility personnel and family responded to the call. The resident was transported to a local hospital where he was admitted on a Legal 2000 - psychiatric hold. The family of Resident #1 was able to determine the resident went to a local hospital emergency room after he escaped from the memory care unit on 1/4/11 and was admitted under his own name. The resident's family reported the facility assured them they were checking with all the local hospitals as part of their effort to locate the resident so they did not go to the hospitals to look for Resident #1. They related that after the resident was discharged from the hospital, he went to a behavioral health facility for five weeks and is now in a group home where he is doing well. Resident #1 had previously left a local a local hospital emergency room against medical advise after being admitted for evaluation after a fall that occurred at 4:00 AM on 12/16/11. The resident was missing for a period of seven hours and was found at approximately 11:00 AM on 12/16/11. The resident also had a history of wandering when living with family. Therefore, the resident was documented by the facility to be an elopement risk. Resident #1's files document that from 10/1/10 through 12/30/10, the resident was on two hour checks that were conducted to determine the residents whereabouts. The two hour checks were discontinued on 1/1/11. Based on the evidence, the facility's failure to provide protective supervision led to Resident #1 being missing for six days and being hospitalized.	Y 515		

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Y 515	Continued From page 5 This was a repeat deficiency from the 11/2/09 annual survey. Severity: 3 Scope: 1	Y 515		